Gates Chili School District

PUPIL SERVICES DEPARTMENT
3 Spartan Way
Rochester, NY 14624

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your health care provider will require the release of information form below to share Protected Medical Information with the school district. Please read and sign below.

I, _____, authorize my child's health care provider(s) listed below to release the medical records (including immunizations, health appraisals, and past/current medical conditions and their impact on attendance, school programming, and/or PT/OT/ST needs) of my child, _____, to the school district's medical officer, physical/ occupational/speech therapist, counselor, social worker, psychologist and/or school nurse.

HC Provider_____Phone_____

HC Provider_____Phone_____

HC Provider_____Phone_____

HC Provider_____Phone_____

The Protected Health Information may be used, disclosed, or received for the purposes of developing care or therapy plans for school management, designing appropriate educational programs, assessing school observations/concerns surrounding behavior and/or student health, assessing a medical basis for modification of transportation and/or tutoring (home or district-based), and medication delivery and/or therapy prescriptions for PT/OT/ST.

This authorization for release of information shall be in force and effect until no longer a student in the Gates Chili School District, at which time this authorization expires.

- I acknowledge that I have the right to revoke this authorization at any time by sending written notification to my health care provider and to the District Administration Building.
- I understand that the revocation of this authorization is not effective if the health care provider or district has used the authorization for the disclosure of Protected Health Information before my written revocation notice.
- I understand that any Protected Health Information disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.
- I understand that my child's treatment, payment, enrollment or eligibility for benefits is not dependent on my agreement to release or withhold information.

_____	_____	_____
Date	Signature of parent or guardian, or student over 18	Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult student or parent/guardian